Welcome!

Thank you for considering our treatment services. Dr. Christopher Carlow, D. Ac. believes health care needs a holistic and complementary approach that promotes natural healing without dangerous side effects. This nurturing approach to healing has the potential to empower the patient with a higher level of self-awareness promoting wellness for a healthy mind, body, and spirit. In addition to offering acupuncture, herbal medicine, whole food nutritional supplements, diet and lifestyle counseling, we also offer massage therapy, reflexology and reiki - more info is listed on the left navigation menu on our website – www.NaturesHealing.info.

Before treatment begins your health history will be evaluated in detail. It is important to complete the Patient History Form in detail before your consultation to ensure the best evaluation. During the consultation you will have a chance to ask questions about treatment. Your health and comfort in the treatment process is very important to us!

This traditional medicine is based on a different set of principles for diagnosing and treatment. This medicine is not disease-based but pattern-based which is to say two people diagnosed in Western medicine with the same disease may display different signs and symptoms making each patient’s diagnosis and treatment unique under the medical scope of Acupuncture and Oriental Medicine. It is also important to consider this medicine as a form of therapy, which often requires multiple treatments. People often ask, how many treatments will it take? This is difficult to determine because each patient is treated as individuals with unique imbalances and lifestyles that can change the course of treatment time. In general, a course of therapy would be 10 to 12 treatments to observe a beneficial response. Some conditions may require 1 treatment per week. The benefits of acupuncture are accumulative and some conditions may require multiple treatments per week for better results. This can be determined during your initial consultation. Acupuncture and Herbal Medicine greatly emphasizes practices in prevention. Therapy can include maintenance and general wellness treatments to promote balance in health.

Cancellation Policy: Business hours are by appointment only. A room will be reserved specifically for you generally without delay, so it is important to arrive on time. We'll be happy to reschedule your appointment with at least 24 hours notice. As valuable time, space and resources are reserved for your appointment; a minimum of 24 hours notice is required when canceling your appointment. Patients canceling with less than 24 hours notice will be charged $20. Only notification by telephone is accepted. Infrequent ability to monitor e-mail makes it an inefficient means of communication. Clinic hours are limited so a timely cancellation can help make the treatment room available for other patients.

We also offer Wellness Workshops on various health topics including Nutritional Counseling, Lifestyle Counseling, Chinese Herbal Medicine, Tui Na Massage, Tai Chi Chuan & Chi Kung - all based on the time-honored principles of Traditional Oriental Medicine and integrated into a patient’s course of treatment within the medical practice of Acupuncture & Oriental Medicine. In modern times there is a misconceived attitude that suggests - “DON’T FIX IT UNTIL IT BREAKS”, but age-old wisdom conveys a superior approach - “PREVENT IT BEFORE IT HAPPENS”. Prevention is the key to good health. “An ounce of prevention is worth a pound of cure.” You can provide the best care for yourself if you have the knowledge. Self-cultivation and self-care can shine a path to optimal health. To be notified of upcoming workshops please include your email on the following form or join the Nature’s Healing E-Mail list at www.NaturesHealing.info.

Dr. Christopher Carlow, D. Ac. is a licensed Doctor of Acupuncture in Rhode Island and is nationally certified as a Diplomate in Oriental Medicine - a combined certification in Acupuncture & Chinese Herbology offered by the National Certification Commission for Acupuncture and Oriental Medicine with staff privileges at Kent County Hospital. He holds a Masters Degree in Acupuncture and Oriental Medicine with special training in Medical Chi Kung and Tai Chi Chuan. Chris holds certifications as an Assistant Chi Kung Instructor by Dr. Yang, J wing-Ming, YMAA and as a Arthritis Foundation Tai Chi Program Instructor.

PATIENT CONFIDENTIALITY IS HIGHLY RESPECTED. ALL COMMUNICATION IN THIS DOCUMENT IS CONSIDERED CONFIDENTIAL INFORMATION IN ACCORDANCE WITH FEDERAL HIPPA REGULATIONS.
Welcome! This questionnaire is a very important diagnostic procedure for assessing your health. Please take the time to thoroughly complete this form. Your personal information will be kept confidential according to federal HIPPA regulations.

1. PATIENT INFORMATION

<table>
<thead>
<tr>
<th>a. Name</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Street</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone: Home</td>
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<td></td>
<td></td>
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<tr>
<td>Email</td>
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<tr>
<td>Emergency #</td>
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<td></td>
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<tr>
<td>Fax</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b. Phone: Home | c. Date of Birth | d. Occupation | e. Health Ins. |
| Address | Street | City | State | Zip |
| Email | | | |
| Emergency # | | | |
| Fax | | | |

If you are not the primary Ins. Holder: Referred by | Marital Status | Primary Name | Relationship to Primary |
| | M | S | D | W |

f. Physician’s Name | Phone | Date of Birth | Relationship to Primary |
| Address | | | |

2. CASE HISTORY – PURPOSE OF VISIT

Chief Complaint | Onset Date

| List symptoms, location, duration, severity |

| List any conditions that make your symptoms better or worse: Better | Worse |

Complaint is the result of [ ] Auto Accident [ ] Injury [ ] Job Related [ ] Other

Other Concurrent Therapies

Have you seen other doctors about this condition? YES / NO If yes, when?

If yes, list doctor’s name and treatment results:

Please list current prescriptions, over-the-counter medications, supplements, herbs, and vitamins (attach additional pages if necessary):

<table>
<thead>
<tr>
<th>Names of Medications Taken</th>
<th>Purpose/Use</th>
<th>Any Side Effects?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

3. FOR FEMALES

Are you pregnant? YES / NO IF YES, HOW LONG?

4. FOR MINORS

List both parents names and addresses

5. PATIENT’S PAST MEDICAL HISTORY (check all that apply and include dates in spaces provided)

<table>
<thead>
<tr>
<th>Allergies</th>
<th>High blood pressure</th>
<th>Heart disease</th>
<th>Seizures</th>
<th>Thyroid disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Surgeries</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Birth trauma</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Frequent colds</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Venereal disease</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Food/med allergies</td>
<td>Heart disease</td>
<td>Seizures</td>
<td>Thyroid disease</td>
<td></td>
</tr>
</tbody>
</table>

Additional comments / Other:

6. LIFESTYLE

Do you drink coffee or soda? YES / NO Do you smoke? YES / NO Do you use recreational drugs? YES / NO

How many drinks per day? How many packs per day? How many times per week?

How many times per week? How many drinks per week? Stress level (1 min – 10 max)

---- TURN OVER PLEASE →
7. FAMILY MEDICAL HISTORY

- Alcoholism
- Asthma
- Diabetes
- High blood pressure
- Seizures
- Tobacco use
- Allergies
- Cancer
- Heart disease
- Recreational drugs
- Stroke
- Tumors/Growths

Additional Family Medical History Comments:

8. EXERCISE

Describe any exercise you may practice

9. DIET

Breakfast
Lunch
Dinner
Snacks
Beverages
Cravings

10. GENERAL

(please check √ any you are currently experiencing and X any that you have experienced in the past)

- Poor appetite
- Heavy appetite
- Insomnia
- Fatigue
- Cold hands
- Cold feet
- Poor coordination
- Sudden energy drop at __________ (time)
- Peculiar tastes / smells
- Bleed or bruise easily (where)
- Strong thirst (cold / hot drinks) ___________
- Change in appetite
- Peculiar tastes / smells _________________
- Bleed or bruise easily (where) ________________________
- Cravings ____________

Additional comments / Other:____________________________________________________________________________________

11. Head, Eyes, Ears, Nose, Throat

(please check √ any you are currently experiencing and X any that you have experienced in the past)

- Concussions
- Eye pain / strain
- Blurry vision
- Ear ringing / tinnitus
- Mucus
- TMJ / jaw problems
- Facial tension / pain
- Night blindness
- Cataracts
- Sinus problems
- Dry throat
- Spontaneous sweating
- Headaches
- Other head or neck problems
- Poor vision
- Nose bleeds
- Sore(s) in mouth
- Obstructive sleep apnea
- Headaches
- Other head or neck problems
- Recurrent sore throats

Additional comments / Other:____________________________________________________________________________________

12. Respiratory

(please check √ any you are currently experiencing and X any that you have experienced in the past)

- Chest pain / pressure
- Difficulty breathing
- Night sweats
- Persistent coughing
- Asthma
- Spontaneous sweating
- Shortness of breath
- Restricted breathing
- Pleurisy
- Phlegm / Mucus
- Signs of cold
- Bad breath
- Gas
- Earaches
- Other head or neck problems
- Recurrent sore throats

Additional comments / Other:____________________________________________________________________________________

13. Gastrointestinal

(please check √ any you are currently experiencing and X any that you have experienced in the past)

- Abdominal pain
- Bad breath
- Black stools
- Blood / pus in stools
- Colitis
- Recurrent belching
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Weight loss
- Motion sickness
- Nausea
- Heartburn
- Rectal pain
- Appetite change
- Recurrent hiccups
- Ulcers
- Vomiting
- Weight gain
- Hepatitis B or C
- Gall Bladder disease
- Laxative use:_________/week; type____________________  Additional comments / Other:______________________________________

14. Musculoskeletal

(please check √ any you are currently experiencing and X any that you have experienced in the past)

- Ankle pain
- Wrist pain
- Shin pain
- Upper back pain
- Broken bone(s)
- Decreased range of motion
- Knee pain
- Elbow pain
- Neck pain
- Lower back pain
- Joint pain
- Sensitivity to weather
- Leg pain
- Arm pain
- Hand pain
- Muscle pain
- Osteoporosis
- Facial pain
- Hip pain
- Shoulder pain
- Foot pain
- Traumatic injury
- Arthritis
- Rib pain

Additional comments / Other:____________________________________________________________________________________

15. Neuropsychological

(please check √ any you are currently experiencing and X any that you have experienced in the past)

- Speech problems
- Numbness / tingling
- Bad temper
- Hearing voices
- Concussion
- Difficulty staying asleap
- Obsessive thoughts
- Seizures / Epilepsy
- Paralysis
- Panic attacks
- Fever / chills
- Loss of consciousness
- Compulsive behavior
- Depressed mood
- Loss of balance
- Vertigo / dizziness
- Insomnia
- Difficulty falling asleep
- Dreams / nightmares
- Paranoid thoughts
- Anxiety
- Shakes / tremors
- Shingles
- Poor memory
- Treated for emotional problems
- Easly stressed
- Considered/attempted suicide

Please list any psychological problems you have been treated for, if any?____________________________________________________
16. Skin and Hair (please check ✓ any you are currently experiencing and X any that you have experienced in the past)

- [ ] Change in skin color
- [ ] Boils / Carbuncles
- [ ] Acne
- [ ] Ulcerations
- [ ] Dandruff
- [ ] Change in hair texture
- [ ] Easily bruised
- [ ] Eczema
- [ ] Hair loss
- [ ] Hives
- [ ] Itching
- [ ] Sores that don’t heal
- [ ] Pimples
- [ ] Rashes
- [ ] Swelling
- [ ] Change in hair texture
- [ ] Eczema
- [ ] Hair loss
- [ ] Hives
- [ ] Itching
- [ ] Sores that don’t heal

Additional comments / Other:

17. Cardiovascular (please check ✓ any you are currently experiencing and X any that you have experienced in the past)

- [ ] Irregular heartbeat
- [ ] High blood pressure
- [ ] Rheumatic fever
- [ ] Chest pain
- [ ] Cold hands / feet
- [ ] Varicose veins
- [ ] Blood clots
- [ ] Bleeding easily
- [ ] Heart disease
- [ ] Fullness in chest
- [ ] Low blood pressure
- [ ] Angina
- [ ] Stroke
- [ ] Heart murmurs
- [ ] Fainting
- [ ] Palpitations / fluttering
- [ ] Swelling of feet / ankles
- [ ] Phlebitis

Additional comments / Other:

18. Genitourinary (please check ✓ any you are currently experiencing and X any that you have experienced in the past)

- [ ] Change in urine flow
- [ ] Sexual dysfunction
- [ ] Blood in urine
- [ ] Frequent urination
- [ ] Frequent UTI
- [ ] Decreased sexual desire
- [ ] Unable to hold urine
- [ ] Sore(s) on genitals
- [ ] Genital pain
- [ ] Urgent urination
- [ ] Discharge
- [ ] Burning upon urination
- [ ] Waking up to urinate
- [ ] Restricted urination
- [ ] Impotency
- [ ] Pain on urination
- [ ] Kidney stones
- [ ] Pain during intercourse
- [ ] Menstrual changes
- [ ] Changes to body / psyche prior to menstruation

Additional comments / Other:

Are you sexually active?   YES / NO

How many times do you urinate per 24 hours?

Describe the qualities of your urine: Clear / Yellow / Scanty / Cloudy / Strong smelling

19. OB/GYN (for females only - please check all that apply)

- [ ] Pregnancies
- [ ] Miscarriages
- [ ] # of Births
- [ ] Birth control
- [ ] Premature births
- [ ] Amenorrhea
- [ ] Breast tenderness
- [ ] Hot flashes
- [ ] Vaginal discharge
- [ ] PMS
- [ ] Changes to body / psyche prior to menstruation

Describe your last menstrual

- [ ] Change in flow
- [ ] CLOTS
- [ ] Heavy flow
- [ ] Irregular flow
- [ ] Light flow
- [ ] Painful menstruation

Last menses

Color

Duration

Age at 1st menses

Age at menopause

Additional comments / Other:

20. CLASSICAL (check all that apply to describe your preferences)

General mood / emotionally

- [ ] Angry
- [ ] Joyful
- [ ] Worried
- [ ] Pensive
- [ ] Sad
- [ ] Scared
- [ ] Frightened

Favorite season(s)

- [ ] Spring
- [ ] Summer
- [ ] Late/Indian summer
- [ ] Autumn
- [ ] Winter

Least Favorite season(s)

- [ ] Spring
- [ ] Summer
- [ ] Late/Indian summer
- [ ] Autumn
- [ ] Winter

Favorite climate

- [ ] windy
- [ ] Hot
- [ ] Humid
- [ ] Damp
- [ ] Dry
- [ ] Cold

Least favorite climate

- [ ] windy
- [ ] Hot
- [ ] Humid
- [ ] Damp
- [ ] Dry
- [ ] Cold

Favorite(s) you enjoy

- [ ] Sour
- [ ] Bitter
- [ ] Sweet
- [ ] Acrid/Pungent/Spicy
- [ ] Salty

Favorite(s) you dislike

- [ ] Sour
- [ ] Bitter
- [ ] Sweet
- [ ] Acrid/Pungent/Spicy
- [ ] Salty

Favorite time of day

- [ ] Before sunrise
- [ ] Morning
- [ ] Afternoon
- [ ] Evening

Problematic time of day

- [ ] Before sunrise
- [ ] Morning
- [ ] Afternoon
- [ ] Evening

Favorite color(s)

- [ ] Green
- [ ] Red
- [ ] Yellow
- [ ] White
- [ ] Blue
- [ ] Black
- [ ] Purple

Final comments / Other:

Additional comments / Other:

Additional comments / Other:

I understand the information I provided on this questionnaire is essential to determine my health and treatment needs. I have read and understood each question and certify it to be true and correct to the best of my knowledge and belief and hereby grant authorization for treatment, in accordance with state statutes, for the care and management of this complaint.

PATIENT’S SIGNATURE  __________________________________________              DATE  ____________

(PARENT’S SIGNATURE IF PATIENT IS A MINOR)